Office of Human Resources
University of Minnesota

UPlan

My Medicine Record:

Member Name: _____ **Medicines as of:** _____

Allergic to: *(Describe reaction)* _____

_____

List all medicines you are currently taking. Include prescriptions (examples*: pills, inhalers, creams, shots*), over-the-counter medications (examples*: aspirin, antacids, vitamins*) and herbals (examples: *ginseng, gingko*). Include medications taken as needed (examples: *nitroglycerin, inhalers*). **Take this form with you when you visit your provider.**

Start Date	Name of Generic or Brand prescription or OTC medication	Dose and Directions: *(How do you take it? When? How often?)*	Reason for taking?	Date Stopped

Important Phone Numbers:

Doctor's name:	Doctor's name:
Clinic name:	Clinic name:
Phone number:	Phone number:
Pharmacy name:	Emergency contact:
Phone number:	Phone number: